DEPARTMENT OF HEALTH AND HUI , SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445215	A. BUILDING _____ B. WING _____	04/14/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE CENTER, THE	1026 MCFARLAND STREET MORRISTOWN, TN 37814

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	F 225	F-225 Reporting of Alleged Abuse 1.) The alleged abuse was reported in the UIRS on April 28, 2011. 04-28-11 2.) Any resident that makes an allegation of abuse has the potential to be effected. Resident council was addressed for any abuse concerns with education on the abuse reporting process. Care plans reviewed of any resident at risk for abuse for any needed follow up. Unit staff education was provided on reporting of alleged abuse. 05-27-11 3.) All allegations of abuse will be reported to the State Agency as required and verified by the Executive Director or the Director of Nursing on a case by case basis. 05-27-11 4.) All allegations of abuse will be reported to the Performance Improvement Committee monthly for three months for review and recommendation. The committee consists of The Executive Director, Director of Nursing, Medical Director, Assistant Director of Nursing, Staff Development Coordinator, and Department Directors. 05-27-11	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Executive Director	4-28-11

y deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that ıer safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 'owing the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 ys following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued ıgram participation.

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F 225	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on medical record review, review of facility documentation, review of the facility policy and interview, the facility failed to report an allegation of abuse for one (#31) of thirty-one residents reviewed. The findings included: Resident #31 was admitted January 5, 2011,with diagnoses including Hypertension, Arthritis, Osteoporosis, and a history of a fall at home on December 2010 with fractures of the left clavicle and a compression fracture of the pubis ramus resulting in hospitalization and subsequent admission to the facility. Medical record review of the Minimum Data Set (MDS) revealed the resident to have adequate hearing, clear speech and clear comprehension of others. Review of the facility documentation revealed a Certified Occupational Therapy Assistant (COTA #1) "...reported the resident was crying and wanted to go back to bed after a shower. The resident told the COTA 'the girls were making fun of me in the shower and told me to shut up because I was causing a disturbance with the other residents'..." Further review of the facility documentation revealed the resident stated on interview that ...(the resident) was in pain at the time of the incident. Review of the facility policy"Reporting Abuse" revealed "...the administrator or...designee will report such findings to the following persons or agencies within twenty-four (24) hours of the	F 225		

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F 225	Continued From page 2 completion of the investigation...State Licensing and Certification Agencies..." Interview with the Abuse Coordinator, April 14, 2011, at 10:00 a.m., in the Administrator's office revealed an allegation of abuse had occurred January 12, 2011, and an investigation was completed. Interview with the Administrator, in the hall, on April 14, 2011, at 10:30 a.m., confirmed the allegation of verbal abuse was not reported to the state agency.	F 225		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to follow the physician's orders for one (#20) of thirty-one residents reviewed. The findings included: Resident #20 was admitted to the facility on March 31, 2011, with diagnoses including Falls, Fractured Hip, status post surgical repair of the fracture, and non-weight bearing.	F 309	F-309 Care and Services 1.) Resident # 20 had T.E.D. hose applied as ordered on the evening of April 14th, 2011. 04-14-11 2.) Residents having an order for T.E.D. hose have the potential to be effected. All residents with ordered T.E.D. hose were evaluated for proper placement as ordered by physician. 05-27-11 3.) All nursing staff have been educated by the Staff Development Coordinator to check placement of the T.E.D. hose prior to signing the Medication Administration Record to ensure that the T.E.D. hose are in place as ordered. 05-27-11 4.) A 100% visual audit of residents with T.E.D. hose will be conducted weekly for four weeks by the Unit Managers to insure residents that have T.E.D. hose have the hose in place as ordered. Audit results will be reported to the Director of Nursing	

information was placed on the resident care cards (for direct care staff) for improved staff awareness. per DON on 5/4/11, 9:10 a.m.

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F 309	Continued From page 3 Medical record review of the physician's orders dated March 31, 2011, revealed "...TED (Thrombo-embolic-Anti embolic device) (Hose used to prevent embolus or blood clots) hose on in a.m., off at H.S. (bedtime)..." Observation and interview, with Registered Nurse (RN # 1) on April 14, 2011, at 8:45 a.m., revealed the resident seated in a wheelchair, with the lower extremities exposed, and RN#1 described the resident's edema as pitting in the bilateral lower extremities. Continued observation revealed the resident was wearing socks and an indentation was noted at the top of the socks, above the ankles, around the resident's legs. Interview with Certified Nursing Assistant (CNA #1) at the 300 hall nursing station on April 14, 2011, at 8:50 a.m., confirmed the " ...TED hose had not been applied this morning..." Interview on April 14, 2011, at 8:55 a.m., at the 300 hall nursing station, with Licensed Practical Nurse (LPN #2) (LPN responsible for measuring and fitting the TED hose) confirmed no knowledge of measuring or fitting the resident for TED hose or knowledge of the TED hose being applied since the resident was admitted to the facility. Interview with RN #1 on April 14, 2011, at 9:10 a.m., at the 300 hall nursing station confirmed the resident did not have the TED hose on, on April 14, 2011, and confirmed the physician's order had not been followed.	F 309	weekly and monthly to the Performance Improvement Committee for review and recommendation. The committee consists of The Executive Director, Director of Nursing, Medical Director, Assistant Director of Nursing, Staff Development Coordinator, and Department Managers.	
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive	F 315	F-315 Urinary Incontinence	

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F 315	Continued From page 4 assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and interview, the facility failed to provide a timed/scheduled toileting program for one (#20) of thirty-one residents reviewed. The findings included: Resident #20 was admitted to the facility on March 31, 2011, with diagnoses including Falls, Fractured Hip, status post surgical repair of the fracture, and non-weight bearing. Observation on April 12, 2011, at 9:45 a.m., revealed the resident was alert and lying on the bed. Medical record review of the Assessment for Bowel and Bladder Training dated March 31, 2011, revealed a score of 11, which indicated the resident was a candidate for scheduled voiding. Medical record review of the Bladder Pattern Flow Record dated April 1, 2, & 3, 2011, revealed the facility failed to complete the three day Bladder Pattern Flow Record.	F 315	1.) Resident # 20 was placed on a scheduled voiding program on April 12th, 2011. 2.) All incontinent residents have the potential to be effected. Care plans and bowel & bladder programs were reviewed by unit managers for any changes or needed updates. 3.) All nursing staff will be educated by the Staff Development Coordinator or designee regarding the policy on The Bowel & Bladder Program, completion of the Three Day Bladder Pattern Flow Record and completion of the Interim Care Plan. The Three-Day Bowel & Bladder Assessment will be initiated by the admission nurse, charge nurse, or unit manager. Information will be placed on resident care guide for improved staff awareness of bowel & bladder assessment needs. Staff have been educated on this information process. 4.) All new admissions will be reviewed weekly for eight weeks by the unit manager to ensure completion of the Three Day Bladder Pattern Flow Record, follow through on the determined program as identified per the Bowel & Bladder Assessment, and updated Interim Care Plan, that reflects the residents current toileting program. Results of this audit will be reported to the Performance Improvement Committee for review and recommendation. This committee consists of The Executive Director, Director of Nursing, Medical Director, Assistant Director of Nursing, Staff Development Coordinator, and Department Managers.	04/12/11 05/27/11 05/27/11 05/27/11

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F 315	Continued From page 5 Medical record review of the resident's interim care plan dated March 31, 2011, revealed the resident's incontinence was not addressed. Medical record review of the resident's care plan dated April 7, 2011, revealed the plan of care addressed incontinence, which included an approach to "...complete assessment to determine potential for bladder training..." Review of the facility policy for Bowel and Bladder Training revealed, "...Urinary Incontinence Assessment to be completed...within seven days after admission...The Assessment for Bowel and Bladder Training...is to determine if the resident is a candidate for individual training or timed/scheduled toileting..." Interview with Registered Nurse (RN #1) on April 14, 2011, at 11:30 a.m., at the 300 hall nursing station, confirmed the three day Bladder Pattern Flow Record was not completed, and the resident had not been placed on a Timed Bowel/Bladder training program as indicated by the Bowel & Bladder Assessment which was completed on April 31, 2011.	F 315		
F 328 SS=E	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and	F 328	F-328 Special Needs 1.) The oxygen concentrator filters for residents #3, #12, #14, and #21 were cleaned on April 14, 2011 when identified. 04-12-11 2.) All residents receiving oxygen via oxygen concentrators have the potential to be effected. All residents with oxygen concentrators had filters assessment for noted dust or lent on April 14, 2011. 05-27-11	

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F 328	Continued From page 6 Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation, review of manufacturer's recommendations, and interview, the facility failed to ensure Oxygen Concentrator filters were clean for four (#3, #12, #14, #21) of thirty-one residents reviewed. The findings included: Observation of resident #3 on April 12, 2011, at 9:18 a.m., and April 14, 2011 at 10:00 a.m., revealed the resident lying on the bed receiving Oxygen at 2 Liters per minute via nasal canula. Continued observation revealed the Oxygen Concentrator had an accumulation of white debris (dust, lint) on the two filters. Observation of resident #12 on April 12, 2011, at 9:30 a.m., and April 14, 2011, at 10:00 a.m., revealed the resident lying on the bed receiving Oxygen at 4 Liters per minute via nasal canula. Continued observation on April 14, 2011, at 10:00 a.m., revealed the Oxygen Concentrator had an accumulation of white debris (dust/lint) on the two filters. Observation of resident #14 on April 12, 2011, at 9:30 a.m., and April 14, 2011, at 10:00 a.m., revealed the resident lying on the bed receiving Oxygen at 3 Liters per minute via nasal canula. Continued observation on April 14, 2011, at 10:00 a.m., revealed the Oxygen Concentrator had an accumulation of white debris (dust/lint) on the filters.	F 328	3.) Oxygen service company notified of dirty filters identified during survey. Oxygen service company to provide facility with a checklist of all concentrators that receive service weekly. Oxygen service company to check individual concentrators weekly and clean or replace dirty filters. 4.) Facility Central Supply Coordinator to conduct a visual audit of at least 10% of all concentrators for clean filters weekly for four weeks. Audit results to be reported to the Performance Improvement Committee for review and recommendation. This committee consists of The Executive Director, Director of Nursing, Medical Director, Assistant Director of Nursing, Staff Development Coordinators, and Department Mangers.	05-27-11 05-27-11

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F 328	Continued From page 7 Observation of resident #21 on April 12, 2011, at 9:30 a.m., and April 14, 2011 at 10:00 a.m., revealed the resident lying on the bed receiving Oxygen at 3 Liters per minute via nasal canula. Continued observation on April 14, 2011, at 10:00 a.m., revealed the Oxygen Concentrator had an accumulation of white debris (dust/lint) on the filters. Review of the Operator's Manual for the Perfecto 2 Series and the Platinum Series XL, 5, 10, (oxygen concentrators) revealed, "...At a minimum preventative maintenance MUST be performed according to the maintenance record guidelines...In places with high dust or soot levels maintenance may need to by performed more often...Remove the filter and clean at least once a week depending on environmental conditions...conditions may require more frequent cleaning..." Interview with the Oxygen contracted staff on April 14, 2011, at 1:30 p.m., on the 300 hall confirmed "...might have missed cleaning some of the air filters last week (Wednesday)..." Observation (of each of the above resident's Concentrators) and interview with the Registered Nurse Supervisor (RN #1) on April 14, 2011 at 10:00 a.m., on the 300 hall nursing station, confirmed the Oxygen Concentrator filters were covered with white debris (dust/lint) and were not clean.	F 328		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional	F 514	F-514 Clinical Records Content	

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F 514	Continued From page 8 standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview the facility failed ensure the accuracy of the medical record for one (#20) of thirty-one residents reviewed. The findings included: Resident #20 was admitted to the facility on March 31, 2011, with diagnoses including Falls, Fractured Hip, status post surgical repair of the Fracture. Medical record review of the physician's orders dated March 31, 2011, revealed "...TED (Thrombo-embolic-Anti embolic device) (Hose used to prevent embolus or blood clots) hose on in a.m., off at H.S. (bedtime)..." Observation and interview, with Registered Nurse (RN #1) on April 14, 2011, at 8:45 a.m., revealed the resident was wearing socks and an indentation was noted at the top of the socks, above the ankles, around the resident's legs. Interview with LPN #1 on April 14, 2011, at 9:00	F 514	1.) L.P.N. number one identified on the 2567 was educated immediately regarding checking placement of the T.E.D. hose prior to signing the Medication Administration Record that the hose were in place.	04-14-11
			2.) All residents having an order for T.E.D. hose have the potential to be effected. Clinical records of residents were reviewed as well as visual assessment that T.E.D. hose were present and correctly documented.	05-27-11
			3.) All nurses have been educated by the Staff Development Coordinator regarding checking placement of T.E.D. hose prior to signing the Medication Administration Record that the hose are in place.	05-27-11
			4.) A 100% visual audit of all residents having orders for T.E.D. hose will be conducted weekly for four weeks by the Unit Managers to insure that residents with orders for T.E.D. hose have the hose in place. The results of this audit will be reported to the Director of Nursing weekly and the Performance Improvement Committee monthly. The committee consists of The Executive Director, Director of Nursing, Medical Director, Assistant Director of Nursing, Staff Development Coordinator, and Department Managers. audit will also include review of MAR to ensure documentation. per DON on 5/4/11 9:10 AM.	05-27-11

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F 514	Continued From page 9 a.m., at the 300 hall nursing station, revealed the nursing assistants were responsible for applying the TED hose and the nurses documented the application of the TED hose on the Medication Administration Record each shift. Continued interview confirmed LPN #1 did not verify the TED hose were applied to the resident's legs, on April 2, 2011, at 6:00 a.m., but had documented the TED hose were applied.	F 514		